VOL. 17, NO. 2 OCT.-DEC., 1967

Inventory

A QUARTERLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. DEPARTMENT OF MENTAL HEALTH

TREATMENT

REHABILITATION

EDUCATION

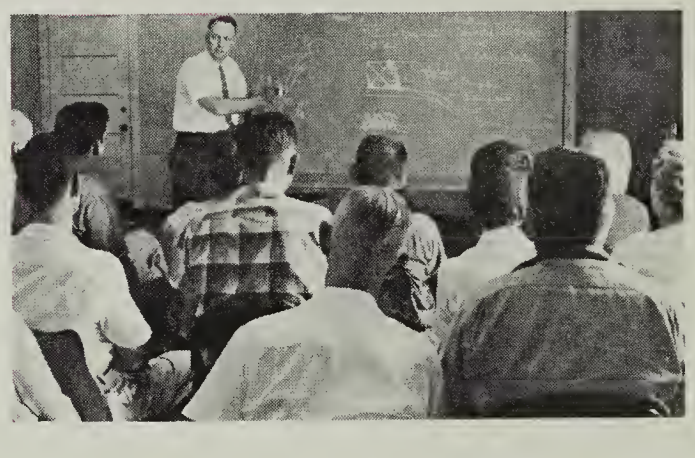
PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham, N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.



A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

Admission Requirements . . .

1. Admission is entirely on a voluntary basis and a person cannot be accepted on court order or legal commitment. The Center cannot accept persons who have any court hearing or legal action pending which would interfere with or curtail their treatment program.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770 or 985-4420). All appointments are confirmed by mail. They should be made through a physician or other professional person in the prospective patient's community.

3. Patients are expected to be sober on admission, and the Center will not admit a person if intoxication impairs his functioning. The Center does not have nursing or hospital facilities to treat acute intoxication.

4. A written report of a recent physical examination by a licensed physician must be presented upon admission. The patient's physical and mental condition must be good enough to enable him to participate in the treatment program, walk up and down stairs, etc. The Center does not have hospital beds or nursing staff for the treatment of serious physical or mental disorders.

5. A fee of $120.00 is charged for the four weeks of treatment. This may be paid by cash or check at the time of admission, or by a note signed by the patient at the time of admission — promising to pay the full sum at some time after discharge.

If a person is indigent he may obtain a letter stating this fact from his local county welfare agency, and upon presentation of this letter at the time of admission the request for payment will be waived.

The Center does not refuse to admit any person because of lack of money, but feels that patients having treatment should take responsibility for the cost of the services if they are able to pay at the time of admission or later.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

Admitting Days . . .

Patients are admitted to the Center five days a week, Monday through Friday, between 9:00 a.m. and 12:00 noon and 1:00 p.m. and 5:00 p.m. by appointments as described above.

N. C. DEPARTMENT OF MENTAL HEALTH

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INVENTORY

OCTOBER-DECEMBER, 1967

VOLUME 17 NUMBER 2

RALEIGH, N. C.

An educational Journal on Alcohol and Alcoholism. Published quarterly by the N. C. Department of Mental Health created by Section 122-1 of the General Statutes of North Carolina. Former Section 122-1 was redesignated by Session Laws 1963 c. 1166, s. 2, as Section 122-7. Section 3 of the 1963 act added present Section 122-1. Offices are located at 441 North Harrington Street, Raleigh, N. C. 27603.

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This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request, with the exception that *new* requests from *individuals* residing outside North Carolina can no longer be accepted. The views expressed in the articles published are those of the authors and not necessarily those of *Inventory*. Manuscripts are invited with the understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina 27603.

SECOND-CLASS POSTAGE PAID AT RALEIGH, N. C. 27602

Who really *knows* what it is like to be an alcoholic—except an alcoholic? Stories like those of Grady B. bring us a little closer to understanding. The learned professions, each to his own, might give it another name and explain it in *their* technical language. Grady B. simply calls it euphoria and explains what it means to him in *your* language.

EUPHORIA

BY GRADY B.

From a glorious "high" feeling to euphoria is only a graduated step. No alcoholic sets out to get drunk. He loses control in the pursuit of euphoria.

NONALCOHOLICS often ask the question, "What do the drunks find in a bottle to make them keep on drinking?" In my opinion this is a fair question. We have all seen varying numbers of alcoholics and I'm afraid we will see a great many more before we come up with enough intelligent answers to make a real beginning on the problem and to answer the question, "What do drunks find in the bottle to make them keep on drinking?"

I am an alcoholic and while I live I shall remain one. Of this I have no doubts whatever. Through the movement known as Alcoholics Anonymous my alcoholism has been arrested for a number of years and I no longer need or want to drink.

As my association with A.A. began to dry me out I often found myself pondering over the path I took that led me into alcoholism. My opinions, presented here, are the result of what I know of my own case and what I have learned through talks with hundreds of other alcoholics. I shall use the word, *he,* to indicate the alcoholic, and very often *he* will mean *me.*

The young drinker will probably discover *euphoria* by accident. Usually, three or four of these youngsters will decide to experiment with a bottle of whiskey. This experimentation will very often end in disaster, sickness and vomiting. Occasionally, even on the first try, one of these youngsters will discover what it is to get *high,* and if he is the one in thirteen who will become an alcoholic, he is on his way.

His approach to whiskey now will be cautious but less fearful. He has been "high" once with no ill effects. He didn't get drunk and he didn't get sick. No sweat,

no pain. He will experiment again and again to get that grand and glorious "high" feeling. From this "high" feeling to euphoria is only a graduated step. Let it be understood now that no alcoholic sets out deliberately to get drunk. It is in the pursuit of euphoria that he loses control. If he can manage his drinks just right, euphoria can be maintained for two or three hours.

Let us say it is Saturday night, 7:00 p.m. He is alone. The wife is spending the night with her family. He has no obligations for Sunday. An opportune time. He opens a bottle of whiskey, pours a three ounce drink, downs it, chases it with a sip of water. He lights a cigarette, picks up the evening paper and sprawls in his favorite chair. He reads the front page of the newspaper and then turns to the sports section, which he peruses closely, his mind alert. The whiskey is beginning to spread out a bit and he feels the glow coming on. It is 7:30 p.m. and he makes another trip to the kitchen, downing another three ounces. Back to the paper, editorials now. Mind still alert. But the whiskey is now beginning to lay powerful hold on his mind. He drops the paper, his head falls on the cushion, his eyes wide open, seeing nothing; his mind beginning to see everything. He has achieved euphoria!

Euphoria is that deep, deep feeling of comfort, of well-being, the uncluttered mind free to roam. He is no longer shackled to everyday things. It doesn't matter if he is too big or too little, ugly or handsome, rich or poor. The world is now completely wonderful. In the world he now sees there is nothing to fear while just an hour ago there was plenty to fear. Tomorrow, next week, next month, life will be wonderful. It is 8:30 p.m. Back to the kitchen. Holding bottle and glass, he debates with himself. Three more or two? Three wins. Nine ounces in less than two hours. He has tipped the scales. He will be drunk shortly —euphoria gone.

". . . that deep, deep feeling of comfort, of well-being . . ."

This scene, with variations, is happening in thousands of homes nightly. *He* is somewhere between twenty-seven and thirty-three years of age. He is in the middle stages of alcoholism. I seriously doubt if there is a non-alcoholic anywhere who could possibly understand the fascination that euphoria holds for the alcoholic. He will attempt, again and again, to get back to this

(Continued on page 31)

Views Exchanged

In your last issue in "Letters to the Program," you spoke of the fact that a person may choose to drink without choosing alcoholism, or to smoke without choosing cancer. However, he can not choose to drink without *running the risk* of alcoholism or to smoke without *running the risk* of cancer.

You are right in saying that not drinking will not guarantee that a person won't have some other kind of emotional illness. But what you do not say is that it is better to have one emotional illness than two.

The Same Interested Churchman
Roanoke, Virginia

Editor's Comment: We all assume risks in our daily lives of greater or lesser degree. A high percentage of us run the risks you mention. An even higher percentage of us run the daily risk of being in an accident, for instance, when we ride in automobiles. Some of us by taking these risks become victims—of accidents, cancer and alcoholism. Yet, as victims, we do not all get the same consideration. Can you imagine a doctor refusing to treat, or a hospital refusing to accept, an accident victim because "the accident was his fault," or a cancer patient because "he didn't approve of smoking?" These victims, including the victims of alcoholism, do not deliberately set out to become victims, yet alcoholics are often treated as described—not only by doctors and hospitals but by other professional persons and agencies as well. I could say, "It is better to be rich and healthy than poor and sick," and get 100 per cent agreement. However, if I said, "It is better to have one emotional illness than two," it would be a matter of conjecture. I may not have all the facts. As to whether in my view "one or two" would be better would depend upon additional information—is the "one" severe and the "two" mild, e.g. I'd rather have a neurosis and an anxiety reaction than paranoia. In regard to alcoholism, we are told that the drinking of some alcoholics actually staves off a psychosis, or a more severe form of mental illness, sometimes for years. Thanks for your interest.

Rehabilitation Worker

Please put me on your mailing list. In my job in vocational rehabilitation there are many alcoholics that I can help more because of the one *Inventory* I have read. Thank you.

George Whitted
Goldsboro, N. C.

Program Planning Aid

The State Legislature of South Dakota has established a Division of Prevention of Alcoholism and Treatment of Alcoholics. The Governor has appointed five persons to act as a board for this division to assist them in program planning for the coming year. Would you please put their names on the mailing list for *Inventory?*

John E. Madigan
Pierre, South Dakota

Used as Resource Publication

Would you place the Office of Alcoholism on your mailing list? I have enjoyed keeping up with the field of alcoholism through *Inventory*. To my way of thinking it is one of the best resource publications.

Glen M. Wilcox, Coordinator
Office of Alcoholism
Dept. of Health and Welfare
Juneau, Alaska

Education of the public is a form of treatment, one of the best, as it is preventative.

BY MRS. HELEN S. KAFER, A.C.S.W.
PSYCHIATRIC SOCIAL WORKER
NEUSE MENTAL HEALTH AND ALCOHOLISM CENTER
NEW BERN, N. C.

TREATING THE ALCOHOLIC IN AN OUTPATIENT CENTER

IN my experience, the alcoholic patient has never voluntarily referred himself to our center for treatment. I would like to think that this is because our center is a fairly new service in our community, but the realistic fact as revealed in research and experience in other centers as well bears out the fact that the patient comes because of outside pressures, even when he is, and has been, suffering physical and emotional agonies. One would think that these agonies alone would bring him in for help in recovering from alcoholism, but, alas, if he comes, he generally wants relief from these agonies so that he can recover enough to begin again the destructive process. The center, the rehabilitation center and the hospital may be used only as rest stops on the way. The further the alcoholic has progressed into the illness, the more difficult seeking help becomes. It is as if alcohol has become his life belt.

In recognition of this fact, a tremendous effort is being made to educate the public regarding the nature and lure of alcohol, the drug, and its sociological, psychological, and physiological dangers to the individual and to society. This is a form of treatment, one of the best, as it is preventative. We all know that preventative treatment has been our most effective tool in checking polio, smallpox, diphtheria, tuberculosis, venereal disease and a host of others. We must face the fact that alcoholism has reached epidemic

Mrs. Kafer's article was originally given November 6, 1967 as a talk at the Ministers Workshop on Alcoholism, sponsored by the Alcoholism Center at Elizabeth City which serves Camden, Chowan, Dare, Pasquotank and Perquimans Counties. The former A.I.C. of the Craven County Council on Alcoholism is now a division of the Neuse Mental Health and Alcoholism Center serving Carteret, Craven, Jones and Pamlico Counties.

status in our country and is undermining one of the basic roots of our society, the family (which has an alcoholic member). The alcoholic employee costs industry hundreds of thousands of dollars annually, these costs being reflected in the price every citizen has to pay in needed goods. We could carry this idea further by mentioning unpaid debts, hours of education lost to children who cannot keep their mind on their books because of their anxieties regarding their home situation, children who become emotionally injured as adults or alcoholic themselves, divorce, death on the highway, suicide, costly hospital bills, etc.

Society does have a tremendous responsibility for the alcoholics within its midst. The time has long since passed when society can laugh one minute at the poor drunk and in the next breath condemn him and seek to cast him out. Society, like the alcoholic himself, has tended to evade responsibility, to deny reality, to procrastinate, and project blame.

I believe this is caused by the fact that society has had no real understanding of alcoholism—nor has the alcoholic or the members of his family. I confess **that** I too evaded the alcoholic until **I** accepted my position as psychiatric social worker with the Craven County Council on Alcoholism. Since that time, I have spent hours studying the problem, the individual alcoholic and his family, and still feel that I have barely touched the surface. This is one reason I am emphasizing education as treatment, for we cannot deal with treatment until we have an understanding of the problem and are ready to face the responsibility.

The Alcoholic Information Center has become the pivot for the dispersing of literature regarding alcoholism, for news releases, for counseling; in fact, a lighthouse, giving hope by showing a way out of the shoals of alcohol. The A.I.C. has established speakers bureaus, workshops, courses on alcohol in high school, in industry, for judicial bodies, etc., has sponsored Flynn Homes, established and encouraged A.A., Al-Anon and Alateen groups. It has given encouragement and support to alcoholics and their families, and made arrangements for treatment. In fact, the A.I.C. most often is the alcoholic's point of departure from alcoholism to sobriety. Through educational efforts, perseverance, and persistence, A.I.C.'s have played a large part in the acceptance by M.D.'s of the alcoholic as a patient and the acceptance of him as a hospital patient under the diagnosis of alcoholism. The centers taught that alcoholics have both a medical problem and a psychiatric problem that can be treated before these facts were truly accepted by medicine, psychiatry and social work. Alcoholics have long been that segment of society everyone avoided if possible, and who were disposed of quickly if avoidance was impossible. No wonder A.I.C.'s and alcoholics have had a healthy, paranoid reaction toward doctors and mental health agencies and institutions. We have all frequently heard the complaint that hospitals just dry the patient out, discharge him, and he immediately or shortly afterwards begins to absorb alcohol again as if he were a human sponge instead of a human being.

Why have hospitals, doctors, psychiatrists, psychologists, social workers avoided the alcoholic? I think the answer is generally twofold. There is no specific treatment as in

Whatever our training, we begin

therapy by examining our own attitudes toward the alcoholic.

pneumonia, and the alcoholic is a most difficult patient to treat. Just as discouragement is often a factor in the alcoholic's resistance to treatment, so too, discouragement leads those who should help to expending their efforts treating patients more favorably inclined to accept help.

Where then do we start treatment with the alcoholic? Regardless of our affiliation or our training, I feel that we have to start with ourselves by examining our own attitudes toward alcoholics and how these attitudes may affect the individual who has come to us for treatment. How do we handle our own hostilities, frustrations and stresses, our own reactions to authority? Can we recognize and deal with the emotional feelings the alcoholics arouse in us? Can we see him as an individual and afford him a place of worth? Can we offer him support or encouragement and handle his tendency to be stickily dependent, his hostilities, his feelings toward authority? Often we hear those who have tried to help the alcoholic say they feel they "have been sucked dry." Can we say that these people have failed the alcoholic or that the alcoholic has failed them? Perhaps the failure lies in both—for expecting too much or too little of the other. Goals often are unrealistic and do not take into account the individual character structure or shall we say, ego strength, or lack of it. An individual is after all a person, who, like the nonalcoholic, is trying to survive, long before he becomes an alcoholic, or has even had his first experience with alcohol.

Much research is going on to determine if there is an alcoholic personality. So far, there has been no definite success. Passive-aggressiveness, passive-dependency and depression, etc. are generally noted in the study of alcoholics, but they are also noted in neurotics and other mental patients who are nonalcoholics. In fact, coping devices such as denial, isolation, projection, overt or masked hostility, repression, rationalization, suicide, etc. are personality characteristics of each group. The alcoholic psychosis may resemble schizophrenia or paranoia. Why then do some individuals turn to alcohol as a way of surviving and others to one of the mental illnesses?

Some researchers feel that the physiological or chemical make up of the individual may tip the scales in favor of alcoholism. People seem to have a degree of tolerance to the drug called alcohol just as they do to other drugs. Thus a person with a low tolerance for alcohol would avoid it before he becomes addicted, while a person with a high or relatively high tolerance for alcohol could become an addict to alcohol before he realized what was happening to him, if he found that alcohol is for him the perfect coping device. As long as alcohol works for him without causing too much pain, he scoffs at the opinion of others that he is an alcoholic.

He does not seek help until alcohol affords him more pain than pleasure. The actual loss of his job or his family or physical incapacity may lead him to seek help or have help forced upon him. In many ways, the alcoholic's behavior resembles that of the three-year-old who feels that the world revolves around him or that of the adolescent who feels much the same way. The parents who coddle or ignore the three-year-

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What's brewing?

A feature designed to help you keep posted on developments in the field of alcoholism.

BURLINGTON, N. C.: The Alcoholism Programs of North Carolina elected a new slate of officers here at its fall meeting on November 10. They are, from left to right below: Marshall Abee of Greensboro, director of Community Health Services, Inc. and immediate past president of the APNC, and Worth Williams of Greensboro, director of the Greensboro Council on Alcoholism, members of the Executive Committee; Tom Ivester of Raleigh, supervisor of alcoholic rehabilitation, N. C. Department of Corrections, vice president; Mrs. Margaret Davis of Wilmington, director of the New Hanover County Council on Alcoholism, treasurer; Robert Charlton of Winston-Salem, educational director of the Alcoholism Program of Forsyth County, secretary; and William Hales of Charlotte, associate director of the Charlotte Council on Alcoholism, president. All officers are elected for two-year terms. The next meeting will be held in Greensboro March 28-29, 1968, on the occasion of Greensboro's locally sponsored "Alcoholism Information Week."

RALEIGH, N. C.: The Fifth Annual John W. Umstead Series of Distinguished Lectures will feature many of the foremost authorities on alcoholism in the United States. Sponsored by the N. C. Department of Mental Health, the audience will assemble February 1-2, 1968, at Raleigh Memorial Auditorium. The chairman and co-chairman of the series are Dr. R. J. Blackley, director of the Division on Alcoholism, and Dr. Norbert L. Kelly, director of the Division on Education. The morning and afternoon sessions will begin at 9:00 a.m. and 2:00 p.m. respectively.

In recognition of the fact that alcoholism is an important concern of a variety of professions, 2000 invitations were mailed throughout the State during Alcoholism Information Week. As a result, the lectures are expected to attract a statewide audience of 400 persons—including practitioners in the fields of medicine, public health, welfare, education, mental health, law enforcement, corrections, rehabilitation and religion, as well as alcoholism.

Thursday's lecturers, in order of appearance, and their subjects will include: Dr. David J. Pittman of St. Louis, Mo., professor of sociology and director of the Social Science Institute at Washington University, "Sociological Aspects of Alcohol and Alcoholism: An International Overview;" and Dr.

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On the occasion of Alcoholism Information Week, Commissioner of Mental Health, Dr. Eugene A. Hargrove (left), announced that alcoholism will be the subject of the 1968 John W. Umstead Series of Distinguished Lectures and issued the first of 2,000 invitations to Governor Dan K. Moore. Governor Moore designated Nov. 26-Dec. 2 "Alcoholism Information Week" and commended both events as "opportunities to learn more about our fourth major health problem." Looking on are, left to right, Dr. R. J. Blackley, director of the Division on Alcoholism, N. C. Department of Mental Health, and Tom Ivester, vice president of the APNC. A.I.W., a nationwide event, is also sponsored by the National Council on Alcoholism.

old or the adolescent will find him reacting with all sorts of unacceptable behavior to have his way, be the center of attention, and have control. We can all think of many ways in which the alcoholic controls the people in his life with his drinking behavior.

Wives or husbands of alcoholics also cannot be characterized as a particular breed of people having well defined character traits that are peculiar only to those who marry alcoholics. The same types of people are married to nonalcoholics. We often overlook the fact that even though the spouse may not be as adequate as we wish, the nonalcoholic spouse is the stronger member of the family and has much to offer us in our treatment of the alcoholic. We must avoid falling into the trap of always feeling "if we had that particular spouse, we would also take to drink." After all, we could seek release in divorce or other ways.

Why Spouses Stay Married to Alcoholics

We could go into a long discussion as to why women or men stay married to alcoholics. Surprising as this may sound, many spouses believe in the vow they make on their wedding day, "for better or for worse." Society has frowned for centuries on spouses, particularly wives, who leave a mate, except in cases of adultery, and even in this incidence, society gives more protection to the man than to the woman.

Also to be remembered is that until recently, most women gave up their opportunities for employment in order to be wives and mothers. By the time most alcoholics become confirmed in their drinking behavior, wives find they have no sellable service in the labor market and that their husband is the only source of financial survival for them and their children. They are then apt to become the protector of their husbands, covering up for them and, at the same time, expressing their hostility and frustrations in nagging, physical symptoms, berating, threats of leaving, religiosity, etc. A husband may not face the reality of his wife's alcoholism, because he desires a mother for his children, or he hides her alcoholism because he feels less a man that he cannot handle his wife. By this time, a vicious circle has been established and each finds plenty of provocation in the other. Also many spouses find their mates are quite acceptable when sober and thus are able to survive the periods of drunkenness for the pleasure enjoyed during the periods of sobriety.

Human nature is so complicated, and at times, so surprising, that I again wish to state that so far no single factor or constellation of factors can be said to produce an alcoholic.

I have mentioned the above because I feel that all who try to treat the alcoholic must see him as a unique individual with a unique background and family. Therapy with alcoholics must be family oriented. One thing seems to stand out fairly clearly and that is that the alcoholic, his family, his boss, and society have to confront him with the realities of his behavior and his present situation. As much as we would like to make the decision for him to obtain and maintain sobriety, we have to accept the fact that he, himself, has to make the decision. We can commit him to an institution against his will and control him as long as he remains confined, but the time comes when he leaves the institution and is on his own. Commitment is often necessary, just as it is in mental illness, for the sake of the patient, his family, and society. The alcoholic

will not recover from his addiction to the drug if his ways of coping have not been interrupted or changed into more acceptable ways of facing life and its frustrations. Like the discharged mental patient, too much stress may lead the alcoholic back to his former way of surviving. We do not give up when the mental patient has a relapse, or when the person with another type of illness has a recurrence, and we should not give up when the alcoholic has a relapse.

Not every alcoholic is forced into therapy against his will. For many hitting bottom, losing job or family or the pending loss of each or either provides the motivation and makes manipulation into treatment unnecessary. This patient may join A.A. or use his inner resources to overcome the addiction.

Keeping the Alcoholic in Therapy

The problem of keeping an alcoholic in therapy is difficult. Many feel that once they have reached sobriety, they can maintain it and that having to receive therapy is a sign of weakness. Many can maintain sobriety with help from A.A. which so far has been the most successful therapeutic agent. Here the alcoholics serve as emotional crutches for each other, and through the twelve steps, go through a maturing process. The life stories they share could be described as vicariously reliving the pleasurable and painful years of alcoholism, as ego builders, and adequate sublimation. I feel that every alcoholic should be encouraged to join A.A. or to accept hospitalization if his defenses are too weak, or if his behavior is menacing. I find, that during the hospital stay, his family has a chance to look at their situation more realistically, to understand their own reactions and modify or change their own behavior toward alcoholism. I find that children of alcoholics also need interpretation of alcoholism.

I find that in most cases of alcoholism, I have only one or two contacts with the alcoholic and his family and that I need to make the most of them. I listen sympathetically but realistically to what the alcoholic and his family have to say. I never attack the alcoholic or his family or use moral judgments. I do try to give him a feeling that we who try to help are interested in him as an individual and that he has a responsibility to himself in his treatment. I try to fan his weak flame of hope, for without hope, each of us loses our initiative no matter what the problem. I always offer continued counseling. The offer is seldom accepted, but I do have two cases who have continued therapy over a nine-month period. One has maintained sobriety, the other has gradually lengthened his periods of sobriety. I do not mean that others I have seen have all returned to drinking. Hospitalization and A.A. have proved sufficient for many. There are others we have not found the way yet to help, but we are not discouraged. These are individuals whose alcoholism has progressed too far to be reversed under present known methods of treatment, whose alcoholism is a coverall for a serious mental illness, have no family or supports in the community, and for reasons unknown.

To sum up, education, hospitalization, medication, A.A., various forms of therapy, are the present major methods of treatment. If these treatment methods are to be strengthened, we must be willing to finance them and to finance continued research. Working together, we hope to find a solution.

Is "Constructive Coercion" Constructive?

Evaluation and Conclusions of the Alcoholic Group Counseling and Therapy Program—Group No. 3

BY EDWARD W. SODEN

PROBATION OFFICER
UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA

"Is 'Constructive Coercion' Constructive? can be considered a sequel to "Constructive Coercion and Group Counseling in the Rehabilitation of Alcoholics" by the same author which was published in the Jan.-March, 1967 issue of *Inventory*. This article may be referred to for details on the Alcoholic Counseling Group and information on the philosophy and rationale for the use of "constructive coercion" in probation and parole.

AFTER 27 weekly meetings a simple questionnaire was devised and used to arrive at certain conclusions regarding the effectiveness of the program and whether or not it was accomplishing its simple aims and goals especially in reference to "constructive coercion."

A total of 11 persons, including one female, participated in the evaluation project which was conducted May 16, 1967.

The report on the results of the project is outlined below. It is presented in the following manner for purposes of simplicity and to permit the examination of the questions and answers from which certain conclusions were drawn. It is to be noted that despite careful explanations some of the participants were somewhat confused in recording their answers. To avoid bias and prevent a "pointing" of answers, no questions were permitted after the project began and the group leader remained out of the area for most of the time.

The following was the explanation of the questionnaire:

"In an effort to be of more help to you throughout the alcoholic group counseling program, your cooperation would be appreciated if you would answer the following questions. Your honest opinion is requested and you are not required to sign this questionnaire."

1. *Do you feel that group discussion meetings are:*

	YES	NO	NO ANSWER
a. Informative	5	2	4
	YES	NO	NO ANSWER
b. Helpful	8	2	1
	YES	NO	NO ANSWER
c. Instructive	5	2	4

If your answer to any of the above is no please explain why.

This section indicates a majority were of the opinion that group discussion meetings were more helpful than informative and instructive, although it is obvious that the opinions revealed by line (b) were not overwhelming. It is evident that this phase of the program was conclusively positive, and therefore is a valuable and proven adjunct to a treatment program such as we conduct.

Since only two gave explanations, quoted below, conclusions thereon are difficult. Yet one clearly outlined one of the basic philosophies of the program.

"Program is helpful only if the person wants to help himself."

"They just don't help me."

2. *Do you feel that Alcoholics Anonymous speakers are helpful to you in terms of better understanding your problem.*

YES	NO	NO ANSWER
9	1	1

This phase of the project is definitely conclusive that selected A.A. speakers are a valuable adjunct to the program. It is also indicative that the cooperation of such *selected* A.A. members contributed much in terms of positive help and understanding. More important—this phase also illustrates the value of the "team approach" in the treatment of the "whole man."

3. *Do you feel that A.A. speakers are helpful because:*

a. They discuss their problem from personal experiences

YES	NO	NO ANSWER
8	1	2

b. Their experiences parallel yours

YES	NO	NO ANSWER
7	2	2

c. They freely discuss their problem

YES	NO	NO ANSWER
8	1	2

d. They are more honest because of their desire to help you

YES	NO	NO ANSWER
8	2	1

e. They follow a simple program in helping themselves

YES	NO	NO ANSWER
8	0	3

f. They are honest in talking about their problem with you

YES	NO	NO ANSWER
7	1	3

In this category the vast majority were of the opinion that selected A.A. members were most helpful and contributed much to help the program achieve its simple goal and aims. It also lends itself to the same conclusions relating to the foregoing item no. 2.

4. *Do you feel that one of the following or a combination of the following would be more beneficial to you:*

a. Discussion meetings only

YES	NO	NO ANSWER
1	5	5

b. Discussion meetings with an occasional educational film

YES	NO	NO ANSWER
5	2	4

c. Discussion meetings with an occasional A.A. speaker

YES	NO	NO ANSWER
6	1	4

d. A.A. speakers only every week with discussion to follow

YES	NO	NO ANSWER
1	4	6

e. Meetings as conducted now

YES	NO	NO ANSWER
6	2	3

Explain briefly your reasons for your answers to question number four.

This section reveals equally divided opinions that (c) and (e) were the most effective with (b) in almost the same category. It is to be noted that there was a strong opinion against (a) and (d).

The following five explanations not only support individual opinions but also support the conclusions of item no. 3.

"A diversified meeting without an agenda is in my opinion more helpful than one when you know what is to take place."

"Because after all is said and done you will still have to want to help yourself."

"I may benefit more from their experiences and truths."

"Because the A.A. speakers make the meeting more interesting, and the movie."

"One is as good as the other."

5. *Have these meetings been helpful to you?*

If Yes—Why?	If No—Why?	No Answer
9	1	1

The almost unanimous positive response as well as the opinions expressed by nine participants is conclusive evidence of the effectiveness and benefits of "constructive coercion" and the program as it is now conducted.

It also illustrates the possible change in "thinking patterns" and a changing philosophy of living on the part of the majority. Only one negative response, it is to be noted, is reflected throughout the questionnaire.

"They are helpful because without them I would have trouble helping myself."

"You can discuss freely your problem with others who know all about it. They are in the same situation."

"I haven't had anything to drink in over 2½ months."

"I'm more aware of my problem and try my best to confide."

"I am not drinking now."

"Because I know I can't drink without getting into trouble and I don't need to drink."

"They take up time when I could be doing something more important."

"Because they have learned me about my drinking and I now understand."

6. *Are you still drinking?*

YES	NO	NO ANSWER
5	6	0

Are you drinking more since attending meetings?

YES	NO	NO ANSWER
1	10	0

Are you drinking less since attending meetings?

YES	NO	NO ANSWER
9	1	1

Have you been able to stop and stay stopped?

YES	NO	NO ANSWER
7	3	1

It is evident that some confusion existed but despite this some interesting and meaningful conclusions

Constructive coercion ha

can be drawn. The answers definitely indicate an awareness of their problem, concern about their problem and positive efforts to help themselves. It would also indicate the truthfulness of their responses which in turn indicates the value and effectiveness of the program.

7. *Do you feel you are a problem drinker?*

YES	NO	NO ANSWER
9	2	0

Do you feel you are an alcoholic?

YES	NO	NO ANSWER
6	5	0

Do you feel you are a problem drinker and not an alcoholic?

YES	NO	NO ANSWER
7	4	0

These three categories have been grouped because of their relationships and in order to draw meaningful and comparative conclusions.

A comparison of answers reveals an all too common general feeling of the stigma which still exists and is of deep concern to all who work in the field of alcoholic treatment and rehabilitation. The overwhelmingly affirmative answers reveal, however, a breakdown of denial mechanisms which is usually the bulwark of the alcoholic's defense.

10. *Have the meetings given you a better understanding of your problem? If yes, please explain why.*

YES	NO	NO ANSWER
10	1	0

The fact that only one answer is in the negative is affirmative evidence of the effectiveness and accomplishments of the program. It again lends conclusive evidence of the effectiveness of "constructive coercion."

These conclusions are further supported by the following nine explanations as in comparison to those in section no. 6.

produced positive results in spite of negative attitudes.

"Because now I have reason to say I do not have to drink if I do not want to."

"Definitely yes. I am able to see more clearly the consequences of alcohol."

"It gives me a chance to express myself and I've been listening too for a change."

"I now know what it's like."

"I'm more aware of my problem and try my best to confide."

"Yes, through educational films, A.A. speakers and group discussions."

"Because I can't control my drinking."

"Because I'm helping myself to understand my problem of drinking."

11. *Have the meetings helped you to help yourself? If yes or no please explain why.*

YES	NO	NO ANSWER
9	2	0

The definite majority of positive answers and the following explanations support the observations and conclusions as reported under item no. 10.

"I turn my energy to other things like sports or outside meetings."

"By seeing other people with the same problem."

"I now know my problem."

"I have better living than before."

"I'm more aware of my problem and try my best to confide."

"Yes, but not because I am told or advised to attend."

"It has helped me to understand my drinking problem better."

"Because I don't even like to keep on talking about my drinking."

"I know what my probem is and I can take care of it myself."

"By trying to stop drinking and by coming to the meetings and understanding others that have the same problem."

12. *What would you suggest be done to improve the program so that it would be of more help to you?*

Only six expressed opinions which are listed below.

"I cannot suggest anything because the way the meetings are handled now, I think this is the way they are supposed to be."

"The program format is excellent now."

"Leave as is. Has helped me."

"The program is great as it is."

"Just as it is now."

"Keep like it is."

The conclusion drawn is that a majority of the group clearly expressed approval of the programing and that the format should remain as it is since it has been accomplishing the purpose for which it was established.

Overall Conclusions

The program, as now conducted, offers a "reality-oriented" treatment approach pertaining to the problems of alcoholism. Also, it has demonstrated the value and effectiveness of the immediate introduction to treatment of alcoholic probationers and parolees upon being received for supervision.

An active and direct approach, when applied immediately, with the goal of inducing a feeling of cohesiveness and unity within the group, has proven its effectiveness and value.

The discussion-only type meetings, a regular part of the program format, in which "everyone speaks" or "round robin" technique is used and occasional "role playing" have proven effective in drawing each person into participation, and has had the effect of each acting in the role of co-therapist.

Interaction has been important in drawing out feelings and opinions about personal problems, and, in such settings, has been effective in thwarting and overcoming the usual pattern of denying a drinking problem.

The participation in Group No. 3 started out, as a whole, with definite negative attitudes but after prolonged treatment they, in spite of themselves, indicated and frequently admitted they had gotten help. This definitely emphasizes the effectiveness

(continued on page 24)

The real paradox is this: Public service agencies are beginning to succeed in convincing our people that alcoholism is an illness. General practitioners are prepared to treat intoxication and the withdrawal period which follows. But as families are convinced that early recognition and treatment are preferable to allowing the disease to progress, are physicians willing to accept the reality of alcoholism before the physiological phases of addiction or chronicity? The medical community of today virtually ignores the prodromal and crucial phases of alcoholism.

THE PHYSICIAN AND ALCOHOLISM — A SOCIAL D

BY REV. JOSEPH L. KELLERMANN
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CHARLOTTE, N. C.

This article is based on a talk presented by the author before the annual meeting of the North Carolina Academy of General Practitioners in Durham, N. C. on October 26, 1967. Rev. Kellermann gained his experience in the field of alcoholism as an Episcopalian pastor and later, on up to the present time, as director of the Charlotte Council on Alcoholism. He has lectured and written extensively on the subjects of alcoholism and the clergy and alcoholism and the family. Many of his writings have been compiled in manual format or reprinted as pamphlets and are used extensively throughout the country.

ALCOHOLISM as an illness cannot appear in isolation, progress in isolation, or sustain itself in isolation. It takes two or more persons to produce alcoholism. One person drinks in an abnormal fashion, others react to this drinking behavior, the drinker responds and drinks again. This second drinking episode sets up another cycle of drinking, reaction and response. We call this social disorder alcoholism. Alcohol is the agent, the individual who drinks in an abnormal fashion is the host, the family as part of a particular segment of society is the immediate culture in which the illness is nurtured or progresses.

The role of the physician if properly played may assist in the recovery from alcoholism, or if improperly played may actually perpetuate the social disorder and thereby prolong the illness. As a pastor I have witnessed the untimely death of alcoholic members of my parish, usually during their mid-forties, despite the fact that no medical services were denied or refused them. They merely continued to drink and death resulted. These persons were treated, when intoxicated, for the consequences of intoxication but not for alcoholism. Looking back upon these cases I am aware that death resulted because these persons were not treated for alcoholism. The role of the pastor, the doctor, the family

and others was played out in a way that perpetuated the illness rather than reduced it.

As with any other bona fide illness, the earlier alcoholism is detected and properly treated the greater is the chance for recovery. However, our present attitude is that we refuse to recognize alcoholism until it has reached the chronic or acute stage. By this time the patient is very sick but, far more important, the family may be sicker than the patient due to the impact of the illness. In dealing with alcoholism we are faced with a profound and complex form of mental illness which has the ca-

alcoholisms. Since explanations of them may be found in available literature, I will simply mention the minor varieties:

The situational alcoholic is one who drinks excessively if life gets too tough for him, but there is apparently no progression in his illness.

Another variety is the person whose reaction to alcohol is so toxic that the drinking span is very short but he becomes acutely ill soon after he begins to ingest alcohol.

A third variety is the alcohol dependent who never drinks to the point of intoxication, but uses it constantly as a mild tranquilizer. He

N'S ROLE IN RECOVERY FROM: SORDER and FAMILY ILLNESS

pacity to destroy the emotional stability and, at times, the sanity of the family. For the patient alcohol is a chemical comfort while acting as a physiological curse. If the alcoholic is permitted to treat his own mental illness with the instant acting drug, alcohol, the family may reach the point of interaction that is so destructive that little chance of recovery exists unless the family is first willing to enter into a process of education and therapy for themselves.

In order to understand the family reaction it is necessary to have some knowledge of the chronology of alcoholism and the progressive changes which occur within the family as the illness is permitted to go unchecked. But, first, it is necessary to understand that there are a variety of

performs well as long as he drinks, but may undergo withdrawal symptoms if he stops drinking.

Occasionally we see what was once called the dipsomaniac—a man who goes on a binge with many months of sobriety in between. As a rule these drinking bouts are precipitated by genuine depression in which drunkenness is a choice between suicide or insanity.

Any of these may progress into the type most frequently seen in America and found almost exclusively among members of Alcoholics Anonymous—nonremittent or *progressive* alcoholism. This fifth type has four distinct phases in its development:

First, there is the prealcoholic stage which is revealed by the simple manifestation of excessive use of

alcohol when drinking occurs. The person drinks more than others, more often than others, and drinking means far more to him than to others. The median age for this stage is 18-29 years or a span of a dozen years during which most men enter marriage and beget children. Control is still possible even though there may be a mild social disorder.

The first loss of memory, indicative of the second stage, occurs at a median age of about 29 years. This is termed alcoholic amnesia or blackout. A blackout is a failure to remember after he stops drinking what happened during a period of time when the person was drinking or intoxicated. One blackout when severely intoxicated means nothing. Reoccurring blackouts are medical proof of the existence of alcoholism in its prodromal phase. At this point, the individual should cut back to very small amounts of alcohol or, if this is not possible which is true for most persons in this condition, all ingestion of alcohol should stop and complete abstinence practiced. However, at this point the prodromal alcoholic starts to conceal drinking by gulping or sneaking his drinks.

The third stage of alcoholism appears with the loss of the ability to abstain. Drinking now becomes compulsive and disruption of social life becomes severe. The denial mechanism, key to understanding the mental illness complex of this disease, now manifests itself in the alibi system—unwillingness to admit the loss of control or ability to abstain. The median age for this phase begins at 33 years, although I have had clients reach it in their late teens and one who entered it at the age of 73. Although past drunken episodes disrupted family life, the time and place of the initiation of drinking was one of volition. Now the involuntary or compulsive nature of the initiation of drinking disrupts every form of normal social life for the drinker and the family. The wife who first ignored the drinking, then failed to control it, now finds family life in a state of chaos and confusion. In an effort to prevent this she takes charge and begins to assume the role of head of the house. She and the children become an inner family with the alcoholic as an attachment. This isolation includes withdrawal from many social activities in an effort to conceal the illness from those outside the family. Both forms of isolation intensify the emotional conflict between the husband and wife during the crucial phase.

As the alcoholic approaches 40 the chronic stage or the beginning of addiction appears. The alcoholic now loses the ability to sleep off a drinking episode. Medical complaints occur just before or just after this transitional phase of the illness. Alcohol is no longer just an anesthetic. It has now become a very toxic drug. Drinking episodes now consume not one evening but two or three or several days. The fear of the beginning of a drinking episode and the terror of going through it add to the distress of the wife and consequently the impact on the children. Family life now becomes a series of intermittent drinking episodes with varying periods of sobriety between them. By this time, the mental health and social life of the family is disrupted, the economic status insecure, and the physical health of the drinker is critical. Unless the drinking is eliminated, the patient may die in his late forties or early fifties. Some may be getting drunk in their seventies, but others will

in time, is often fatal before the drinker reaches fifty.

have lost their lives in their early forties. Having conducted far too many burial services for alcoholic members of my former churches, I am convinced that alcoholism is a chronic, progressive illness, which, if not arrested in time, is often fatal before the drinker reaches fifty.

The chronology of the illness transpires slowly, but progressively, over a period of some 20 years. By the time the alcoholic patient seeks medical help for withdrawal symptoms or is suffering from severe organic difficulties from overdrinking, the illness has produced devastating results in the emotional, social and financial life of the family. Again and again wives tell me their husbands have not been in a doctor's office in years, despite his severe drinking episodes.

As physicians, you hope to detect and treat diabetes in the prodromal phase, yet the medical community today virtually ignores the prodromal and crucial phases of alcoholism. When the chronic and acute phases force recognition of the existence of alcoholism on the family as well as present undeniable evidence to the physician, successful treatment must include information, education and continuing therapy for the family and a treatment program for the alcoholic which must consist of two or three years participation in a recovery program.

This lengthy introduction to alcoholism as a social disorder is presented as evidence to indicate that the physician's role in early detection and treatment is through the family rather than with the patient. It may also include a good look at the morality of medicine rather than rest solely on medical ethics.

Unless you are somewhat different from most doctors your experience with the alcoholic has not been pleasant. The family and/or the patient want treatment on an emergency basis. Rarely is there continuation of treatment and there are repeated relapses. If the physician does accept the alcoholic for treatment, and hopes to bring the illness under control with the cessation of drinking, there must be a realignment of the family. In fact, the physician who hopes to avoid the treatment of chronic alcoholism in the families which comprise his patients, must be willing to treat the spouse or next of kin, not medically, but as a physician, explaining to the wife, husband or others what steps may be taken in a constructive effort to bring alcoholism under control before the more destructive aspects of this illness occur.

During the past two years I may have overused the following vehicle of liberal arts, a description of a tragic sociodrama, but I have found nothing better to replace it. It is offered to enable you to see alcoholism as a social disorder, the vital interaction of the family with the alcoholic, and your role as a physician. How you play this role may help perpetuate the illness or may be the key which unlocks the door to recovery. This vehicle of explanation will also attempt to explode the theory that it is necessary to wait until the alcoholic wants help before initiating treatment. Under our present social, cultural and medical approach to alcoholism the vast majority of alcoholics are unable to accept help and die without knowing, or realizing, they need it. The action of those primary persons in the life

of the alcoholic determine whether he enters into long-range treatment or continues to drink in a fashion that reveals his belief that alcohol is the only answer to life's most desperate problems.

Instead of viewing the alcoholic as a troublesome patient imagine that you are sitting in a theater witnessing the play, "A Merry-Go-Round Named Denial." It is a tragedy in three acts. For the sake of brevity there will be only four characters. In the order of their appearance they are the Alcoholic, the Enabler, the Victim and the Provocatice.

In Act I the alcoholic is the actor and all other characters are the object of the action. He is intelligent, capable, compulsive and very sensitive. However he is usually grossly emotionally immature, and always extremely dependent which he denies by acting in a most independent fashion. No wonder denial is the name of the play because it is the name of the illness. The denial mechanism reveals the need to deny and drinking reveals the need to deny to oneself that the effect of alcohol gives to this person an unbelievable sense of success, well-being and self-sufficiency. If it does not do this to him, it at least lets him forget.

The alcoholic, under the influence of alcohol, goes through a profound change. The pronounced symptoms include blackouts and an extreme switch in conduct and attitude, a Jekyll to Hyde switch. The alcoholic becomes irrational, irresponsible, antisocial, deviant, and in some cases criminal, in his activity. This behavior produces a crisis and some kind of mess. At this point, the extreme dependency becomes evident, especially in the urgency to have the dependency needs met immediately.

In Act II three persons come on

Imagine you're sitting in a

stage. In the action that follows the alcoholic becomes the object of the action of these three.

First to come on stage is the Enabler, a guilt laden Mr. Clean, who sets up a rescue mission to save the alcoholic from the crisis. This may be a member of the family, but usually it is a male outside the family—a friend, neighbor or fellow employee. There are professional persons who also play this role frequently. Doctors, ministers, lawyers, social workers and others in the helping professions are perfectly cast for this role and play it beautifully.

Next is the Victim—the employer, boss, foreman, supervisor or commanding officer or, if the alcoholic is a professional person, the business associate or a key employee. The victim covers and protects the alcoholic by getting the job done while he is drinking and taking him back when it is over. Loss of job would occur much earlier without repeated victimization. The victim is caught from both sides. The alcoholic is his friend for they work together and he has a wife and kids. Also, he is unable to cope with him and is afraid to report to superiors for fear his job would be jeopardized for past failure to cope with it effectively.

The third character is the Provocatice or female provoker, usually the wife but may be mother or sister. This woman provokes, precipitates, coerces, controls, holds together, never lets go, never gives up and never forgets. The alcoholic's attitude is "I can fail you but you must never fail me." Unwilling to admit he is an alcoholic most wives redouble every effort to save the marriage and preserve the home. Almost everything in our culture—her fami-

ly, his family, church, the economic situation and society—combine to enforce this role upon her. No matter what happens she holds on.

The result of act two is rescue of the alcoholic, the preservation of his job and his family by others acting for him. This removes the crisis and cleans up the mess but increases his dependency because he is denied the right to correct his own mistakes and learn by the experience of doing.

In Act III the Alcoholic comes back on stage. The increased dependency of act two necessitates increased denial. He denies he has a drinking problem, denies he drank too much or denies the possibility that he will ever drink again, denies anyone helped him, denies his job is in jeopardy and blames his wife for all his domestic troubles—but he knows this is not true. His underlying omnipotence was humiliated because "god" had to rely on others for help. He is aware of his drunkenness, his failures, and what others did for him, but the nature of his illness prevents him from admitting it to others. There is only one thing he can do to restore his self-image of independence. He takes a drink. When this happens, the merry-go-round has turned 360 degrees, and we start all over again with Act I.

The drama may be acted out frequently or occasionally, but it is always the same show. It becomes so stereotyped that it is like watching an old three-reel movie. In time several persons may play the role of Enabler or Victim and there may be a change in the role of Provocatice, but this is unlikely unless the switch is from wife to mother.

If the alcoholic is to effect a recovery, we must change Act II—not by substituting new persons for the same role but by convincing the same person to play a new role. Everyone tries to change the character of the alcoholic without realizing that he will ride this merry-go-round of denial as long as the supporting cast rides it in the same fashion. We must rewrite and redirect Act II if we anticipate Act III ending in sobriety.

Having taken a look at the play, let us now take a look at ourselves as characters in the play. The minister could be the first effective professional person to aid in the control of alcoholism, but the Classical Temperance Movement in our country has produced so much guilt and shame in regard to drinking and drunkenness that the average family is too embarrassed to approach the minister. The alcoholic projects his guilt toward the minister and eliminates him—unless he desperately needs him as Enabler to get his wife or job back.

The doctor is in much the same position. Alcoholics fear coming to him during the earlier stages of the illness because he might tell them to stop drinking. If the physician tells him to stop drinking, he will continue to drink and stop seeing this doctor or find another who is not aware of his drinking experiences.

The wife is aware of the drinking problem but her shame and embarrassment prevent her from admitting alcoholism. She is much more likely to seek help from her family doctor than the minister. We come now to a real paradox. Voluntary and public health agencies today are beginning to succeed in convincing the people of our country that alcoholism is an illness. The American

Medical Association and the Medical Society of the State of North Carolina have made statements to this effect. Legally the courts may order involuntary treatment, and recently Joe Driver, resident and citizen of the City of Durham, became the first man in the history of our country to be released from prison by order of a federal court on the basis that his sentence for public drunkenness was violation of his constitutional rights because he was a chronic alcoholic.

The paradox is this. General practitioners are prepared to treat intoxication and the withdrawal period which follows. But as we who are working in the area of alcoholism education and information succeed in convincing families that early recognition and treatment is preferable to allowing the disease to progress, are the doctors willing to back the family in this position? Even more important, are they willing to help the wife or family member understand the nature of alcoholism and spell out in clear, concise language what the family must do if they desire an arrest of alcoholism. Are physicians willing to accept the reality of the existence of alcoholism before it reaches the physiological stages of chronic alcoholism? Are they prepared to work with the family in learning how to cope with the illness by seeking help for themselves and making basic changes in their reaction, a step which is so essential in initiating recovery? The Medical Society of the State of North Carolina has published a statement on alcoholism which defines this area of the physician's rseponsibility.

A member of Al-Anon related the following story to me which clearly indicates how a change on the part of the family works. She was given a copy of the pamphlet, "A Guide for the Family of the Alcoholic," at her first Al-Anon meeting. After getting her husband off to work the following morning, she sat down to read the pamphlet with a second cup of coffee and a pencil to underline what she felt was important. As she read each paragraph she said to herself "this is not true" and put a big "X" mark through it. When she finished she was angry, denied that the ideas were true or applied to her. But for two weeks she read the pamphlet at least twice a day. One morning she decided to read it with an open mind and, as she read it, she said to herself, "This is true and every word applies to me." She returned to Al-Anon meetings and worked on its program with a vengeance. Within six months her husband had accepted A.A. and with both of them active in their programs of recovery, they had enjoyed two years of sustained sobriety. The key to recovery was her statement, "I finally realized that if I expected my husband to change that I must change first."

Change in Wife's Role

This profound effect of the change of the wife's role has been noted by others. Dr. John A. Ewing, a psychiatrist associated with N. C. Memorial Hospital and the University of North Carolina, in his individual and group therapy work with families of alcoholics obtained good results in half the cases when the wife was willing to spend several months on her own learning process and therapy.

The difference between untimely death and recovery is the change which occurs in the lives of those who appear on stage during Act II of our drama. The physician is one of those characters. Doctors, ministers, lawyers, social workers, judges and others must change if the alco-

holic is to recover because they have the opportunity to introduce this change to the family as well as the patient. It has been estimated that half the alcoholics of our country have direct contact with some professional person during the course of each year. Most professional persons play the role of enabler rather than bringing the family and the employer into a morally justified conspiracy to bring an end to the merry-go-round of denial.

The largest field of treatment should be secondary prevention of chronic alcoholism through the treatment of alcoholism in the prodromal or crucial stages. This can be accomplished primarily through advice and counsel to the provocatice and also through the employer if the physician is practicing in the field of industrial medicine. This will take additional time initially, but in the long run it will save a great deal of time in repeated treatment of the acute condition because secondary prevention was not achieved.

In some cases the physician may not have contact with the family or patient until the chronic stage is reached. At this point it is imperative to bring the family into the treatment program. If it is the wife of the alcoholic who has turned to him for treatment or advice, the physician must be prepared to help her take definite action which may bring the patient into the treatment program. Dr. Richard C. Bates of the E. W. Sparrow Hospital in Lansing, Michigan defines this area of the physician's responsibility to include "the simple device of calling the alcoholic on the telephone and asking him to come in for a talk—or writing him a letter, with enclosures, offering treatment in a sympathetic fashion."

Many physicians do not want to become involved in the treatment of alcoholism, of course, and too many simply refuse to get involved. There is a proper way and moral way to refuse to treat alcoholism—to spell out to the family what is involved in recovery and offer to go all the way with them if they will go all out in making sufficient changes by entering into their own program of education and therapy on a sustaining basis. There is also a proper way to refuse to treat an alcoholic—not by refusing initial care but by accepting the alcoholic as a patient provided he continues in a follow-up treatment program. If the physciain does decide to refuse further care of the alcoholic, the time to refuse further medical care and treatment is when the patient is cold sober and not suffering from withdrawal. This may be done within the fields of medical ethics and morality of medicine, if the patient denies the reality of his illness by refusing to engage in a long-range recovery program.

Basic Principles, Not Absolutes

These ideas are basic principles, not absolutes. However these principles do work in the vast majority of cases when properly applied, while the principles followed by most doctors, as well as ministers and other professional persons, actually aid and abet the untimely death of the patient. The alcoholic is a past master at manipulation and, if you allow yourself to get on this merry-go-round and ride the horse named "Enabler," you feel exploited because you are being exploited, and this will wind you up in a ball of frustration and hostility.

Another skill of the alcoholic is his ability to sabotage every constructive social activity of his family, including a plan for his recovery. He does this to deny his own in-

ability to cope with situations. This disruption, chaos and confusion of the family is a symptom of alcoholism, a result of the successful sabotage by the alcoholic combined with the shame and embarrassment of the family. Far too many persons try to make this emotional condition of the family the cause of the alcoholic's drinking rather than a symptomatic result of sabotage by the alcoholic.

Part of the recovery process is helping the spouse or parent understand that they did not cause the illness, but that they have been made socially and emotionally sick by it. Though it may not seem fair to them, they need help at this point far more than the drinker if alcoholism is to be arrested. We keep insisting that alcoholism is an illness. If the wife turns to her physician for help and gets none, or even worse gets the brush off, or if the physician falls back on that completely untrue cliche "there is nothing anyone can do until the alcoholic wants help," the wife feels lost and alone. There is hope and there is help available, and who is better prepared to give this to her than the physician.

Adequate care and treatment of alcoholism is possible wherever there is a doctor, nurse, hospital, understanding minister or social worker, Alcoholics Anonymous and hopefully, Al-Anon, which is initially more important than A.A. As doctors you insist on being the captain and quarterback of any medical treatment program. If we are going to win this game against alcoholism, it is time the captain got the team together and took charge by calling the proper offensive and defensive plays. I think you would be surprised by the number of competent persons who would respond if you announced that you were forming a team.

CONSTRUCTIVE COERCION

CONTINUED FROM PAGE 15

and value of "constructive coercion" in such a program.

The answers to the questionnaire, interestingly enough, would make it appear that often two negatives do make a positive—i.e. the number of negative answers conclude on a positive note.

The conclusions, without question, prove that "constructive coercion"—forced exposure—has produced positive results in spite of negative attitudes.

In drawing conclusions related to this project it must be pointed out that the program has only one specific purpose—the treatment and rehabilitation of "problem drinking" (alcoholic) probationers and parolees under our supervision.

It is also important to note that despite initial resistance to this type of program, "constructive coercion" has, in reality, effectively overcome this resistance and produced positive results.

It is felt that this simple project, as did a similar project conducted with Group No. 2, has proven the value, effectiveness and worth of the program as it is now conducted. It has also proven that such a program is a valuable and necessary adjunct or "tool" in the overall program of probation and parole treatment where an alcoholic problem is evident.

The effectiveness of the program has been further evidenced by the voluntary comments of several supervising probation officers in reference to the marked improvement in appearance and general attitudes of those probationers and parolees who have been specifically referred to and participated in the Alcoholic Group Counseling and Therapy Program.

VOL. 17, NO. 2 INVENTORY OCT.-DEC., 1967

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Purposes, Goals and Services of the

Alcoholism Program of Forsyth County

To stress the importance of prevention and education to the field of alcoholism is not to ignore those who are now alcoholics. Our treatment programs are maintained for this group.

BY JAMES E. BURGESS, A.C.S.W.
ADMINISTRATIVE DIRECTOR
ALCOHOLISM PROGRAM OF
FORSYTH COUNTY
WINSTON-SALEM, N. C.

THE Alcoholism Program of Forsyth County was established by joint action of the Board of Aldermen of Winston-Salem and the Board of Commissioners of Forsyth County in 1952. It has been in continuous operation since that time as a public agency. Citizen participation in the agency's operation has been assured through a nine-member Board of Directors. Its financial support has come from appropriations by the boards of aldermen and county commissioners. The program has been assisted by special grants from the State Department of Mental Health in recent years. Now, for the first time, the Alcoholism Program of Forsyth County shares proportionately with other county mental health agencies in the total allocation of state matching funds for mental health purposes. This means that the alcoholism program is recognized as a part of the overall mental health program in the county and receives its support from city, county, and state funds.

Alcoholism has come to be recognized as a most serious and complex health problem. The result is physical and emotional devastation to the alcoholic, deprivation to his family, and considerable loss of productivity to industry, not to mention its contribution to the extent of delinquency and crime. To attempt to meet the problem, the alcoholism program has committed itself to a multifaceted rehabilitative approach to alcoholics who have a desire to help themselves. Our primary goals are prevention, treatment, and rehabilitation. In working toward these goals, we make use of a variety of professional skills.

Preventive measures against alcoholism have included restrictive leg-

islation, such as prohibition laws, religious appeals, increased retail prices for intoxicating beverages, arrests and sentences for drunkenness, revocation of license for driving while under the influence of alcohol, and even increased tax on alcoholic beverages. It is unfortunate, but true, that the results of these attempts at prevention have been less than dramatic. Realism seems to suggest that it is difficult, if not impossible, to prevent the onset of alcoholism. In most instances, the best hope is what has been called secondary prevention—such as education and early intervention in excessive drinking so that major consequences of alcoholism may be prevented. Experience has shown that if alcoholism is detected in its early stages and if the individual can at that point be motivated to seek professional help, in many cases much can be done to prevent the patient from deteriorating into the chronic phase or into the acute stages. If people with drinking problems can be encouraged to seek help in the middle stages of developing alcoholism rather than waiting until the advanced stages have set in, there is much more hope of controlling the addiction.

It is generally agreed that the reduction of excessive drinking must come about primarily from increased prevention. This, then, would suggest greatest educational effort. Our alcoholism program attempts to provide objective, unemotional, accurate information on drinking and on alcoholism. We work toward appropriate and coordinated educational programs for the general public and for children in the public schools. Our information material is also available for use with certain nongovernmental organizations on request from such groups. In addition to printed matter, lectures and visual aid materials are used. Education is one of the many facets in a total treatment program and is coordinated with the agency's overall effort. Our task in alcoholism education is not only to educate the general citizenry but to communicate essential knowledge about alcohol and alcoholism to youth.

To discuss the importance of prevention and education to the field of alcoholism is not to ignore those who are now alcoholics. It is for this group that treatment programs must be maintained. The immediate goals of our treatment program are to improve physical health and well-being, increase emotional stability, and encourage greater social adjustment. Alcoholics are not a homogeneous group. They are diverse socially, economically and psychologically. This calls for diverse approaches to treat and prevent the progression of alcoholism.

Outpatient Treatment and Follow-up

Experience has shown us that while resident care in a general hospital or a special resident center in many cases is appropriate, it is neither indicated nor practical in others. Our alcoholism program provides outpatient services for alcoholics who are not in need of hospitalization but require help in order to offset impending emotional and economic collapse. Because of the known need for it, we are moving toward increased and more intensive follow-up care for those in need of supportive assistance in continuing rehabilitation following hospitalization locally and/or at the state level.

Any individual having a problem with alcohol may come to our offices on the eighth floor of the O'Hanlon Building or call for an appointment. Referrals on behalf of patients are

accepted from relatives, friends, ministers, teachers, or from any member of Alcoholics Anonymous. There is no charge for counseling and the program may underwrite the cost of necessary medical care if the patient is without funds.

Emergency care for acutely intoxicated alcoholics and those undergoing withdrawal symptoms is provided. The agency's psychiatric social worker who serves as coordinator of treatment attempts to put the patient in touch with his family physician, if he has one, or with any other doctor who can and will see the patient for an emergency examination. If the examining physician finds the patient to be in need of emergency hospitalization, he admits the patient to the hospitial and follows him on an inpatient basis for a period not to exceed five days. The initial examination, the inpatient professional services, and the hospitalization are all authorized and underwritten by the alcoholism program. If the patient is found to be able to pay for this special care, he is billed and is expected to reimburse the program.

Should it be medically determined that the patient needs the more intensive treatment provided by either the Alcoholic Rehabilitation Center or John Umstead Hospital at Butner, we will complete arrangements for state hospitalization and provide transportation for the patient. Patients going to the Alcoholic Rehabilitation Center are voluntary patients and are there for short-term intensive treatment, the success of which depends largely on the patient's intent and cooperation. Patients who are mentally ill and who are also excessive drinkers are admitted to John Umstead Hospital under laws governing hospitalization for mental illness.

The outpatient psychiatric services of our program include individual psychotherapy, group psychotherapy and a clinic for couples.

The clinical director, a psychiatrist, conducts a weekly clinic for individual psychotherapy on Wednesday at 1:00 p.m. He encourages frequent contacts on a regular basis rather than infrequent long interviews.

A clinical psychiatrist conducts two weekly group psychotherapy sessions on Tuesday at 6:00 p.m. and 7:00 p.m. with a psychiatric social worker, one for each session, serving as co-therapist.

Another clinical psychiatrist, assisted by a medical secretary, conducts a weekly clinic for couples on Wednesday at 7:00 p.m.

All clinical sessions are held in the offices of the alcoholism program.

Social Work Services

The agency's social work services are under the general direction of the administrative director who is a social worker. In addition, the social work staff includes a psychiatric social worker who acts as coordinator of treatment, a social work trainee, a graduate social work student, and a patient transportation specialist. The coordinator of treatment is responsible for the agency intake and the immediate supervision of the other social work staff.

It is the job of the social worker to talk with the patient and his relatives to learn what the patient was like before he became ill and how his illness has affected him and his family relationships; to maintain contact wtih the family while the patient is in treatment; to work with the clinical diretcor and the other clinical psychiatrists attached to the program; to work with nonpsychiatric physicians in relation to medical care for the alcoholic; to make appro-

priate referrals to medical specialists, agencies, hospitals; and to work with hospital staff and with social workers in a variety of agencies providing social services to alcoholics. Under medical direction, the social worker may also help in a variety of ways with tthe actual treatment program—especially in follow-up and aftercare services.

The attitudes of staff members toward alcoholics are important in the treatment of patients suffering from alcoholism. The right professional attitude toward alcoholism has a direct relatedness to our program's effectiveness and to the patient's benefits. Staff people are encouraged to develop attitudes that will make it easy for the alcoholic to identify them as professionals with an understanding and accepting interest in, and concern for, the problem drinker. If this kind of attitude is nurtured, the social worker will not only be available for regular and emergency sessions but will not be annoyed by needed short contacts as well. The alcoholism program staff people are expected to handle the alcoholic with patience, tolerance, and understanding. This is not to suggest overfriendliness or permissiveness but professional firmness and control.

Fortunately, we are beginning to reach the point in time where the role of the hospital is changing from a medical center concerned only with inpatient care to a community-oriented approach. This is a part of the community mental health framework. There is a greater awareness of two basic shortcomings of many alcoholism programs of the past, namely, the tendency to exclude the so-called unmotivated patient and the almost total absence of aftercare and followup of formerly hospitalized patients. The Forsyth program attempts to meet these two deficiencies with the following approaches:

1. As a public agency, we believe that we cannot reject as unsuitable for treatment any alcoholic referred or coming to us for help. In a publically financed program, with obligations toward comprehensiveness, we cannot exclude the alcoholic because of his lack of motivation. We have come to recognize that in alcoholism one of the primary symptoms is lack of motivation. One of our major tasks, therefore, is to promote motivation. Some of our best efforts will need to be directed to the patient who is not motivated. We must resist the tendency to write off the less educated and the more socially disabled by simply labeling them as "poorly motivated" and forgetting about them.

2. With better coordination of treatment services and the addition of another social work position in the current budget, the Alchoholism Program of Forsyth County is moving toward a collaborative hospital-community approach. By assigning a social worker to the hospitals at Butner on two days each week, on a regular basis, to meet the alcoholic patients from Forsyth County in the hospital by prearrangement and later to welcome them back in the community upon discharge, we believe our program will help the alcoholic and be a valuable service to the community. The social worker will attempt to work with the patient and the hospital staff so that plans for his release can be completed, in so far as possible, based on his special needs. The social worker will utilize several resources, such as family, relatives, friends, social agencies, employment agencies, and vocational rehabilitation personnel in making plans for the patient's return. The local agency's social work

services can assure the state hospitals that the patient will be aided in getting back to the community and that he will have help in maintaining control of his drinking. In assisting with the re-introduction of the alcoholic from the hospital into the community, social work services provide a continuing rehabilitation assistance both to the returnee and the hospital.

The coordinator of treatment would either conduct or have conducted under his supervision interviews with the patient after his return to determine his progress according to his own statement plus other sources, such as relatives, friends, employers (when appropriate). Social workers would not only seek information on the patient's drinking pattern to determine abstinence, improvement, or further deterioration, but to learn about his social and economic adjustment. The patient's family, job, and social relationships are important measures not only of the patient's success but of the effectiveness of our program's professional services.

Medical-Social Work Treatment

The Alcoholism Program of Forsyth County has pioneered in our community in bringing together medical services and social work services in a combined treatment program for the alcoholic. In this coming together of medical and social work personnel, there is provision for sustained personal and family counseling, on a collaborative basis, that has come to be recognized as necessary to the alcoholic's rehabilitation.

We know that we do not have a monopoly in the field of alcoholism. We make no claim to having a corner on the market of treatment and rehabilitation of the alcoholic. The extent of the problem suggests a multi-therapeutic approach. Alcoholics Anonymous with its principles of unity, service, and recovery foster a cohesiveness and an identification among patients that are conducive to rehabilitation.

Pastoral and religious counseling of the alcoholic and his relatives go on every day in our community. Many alcoholics report that religious participation has been a significant factor in helping them to overcome feelings of hopelessness and loneliness. The willingness of ministers and chaplains to consult with patients about their problems is often an important aspect of progress toward rehabilitation.

It is important for us to remember that alcoholism is a condition, the solution of which calls for the coordination of a variety of agencies, disciplines, and skills. Many local agencies and departments work with the alcoholic both in connection with their primary areas of responsibility, as well as in accepting referrals as resource agencies from others dealing with the problem. Among the agencies would be the departments of health, welfare, vocational rehabilitation, education, mental health and child guidance clinics, general hospitals, police and other law enforcement officers, courts, and correctional agencies, as well as other care-giving institutions. The public schools and even the colleges and universities are not immune to the problem—but beyond coping with it as a problem, they carry the important function of teaching about alcoholism.

The services of the program are carried out by the cooperative and collaborative work of a clinical director, two clinical psychiatrists, a psychiatric social worker, a social work traineee, a graduate student social worker, an educational director, psy-

chiatric social work consultant, a secretary-bookkeeper, and a transportation specialist. The clinical director is a psychiatrist as it is the belief of the Board of Directors that the agency's medical director should be a psychiatrist because of the psychiatric implications in alcoholism. The staffing pattern enables the program to provide for both inpatient hospital care at local hospitials and state hospitals for alcoholics through a coordination of treatment of acute intoxication with the long-term treatment for alcoholism addiction. Ours is a patient-oriented service which encourages the patient on recovery from the acute phase to undertake continued treatment for his alcohol dependency or addiction.

We see ourselves as a part of the community psychiatry movement. Early treatment, continuity of services, minimal disruption of the family and dislocation from the community, and maximum social restoration, the hallmarks of community psychiatry, are also our desires for services to the alcoholic. We believe that the treatment and control of alcoholism have a major relationship to mental health services. As the Forsyth County Mental Health Center develops its services to provide a continuity of care for individual patients, we expect the treatment of alcoholics to be included within the range of its comprehensive program and look forward to being a part of the mental health complex. Being one of the component agencies within the County Department of Mental Health since July, 1967, already challenges us to a partnership with other departments and agencies and with a variety of professional and academic disciplines we know to be essential to the effectiveness of the comprehensive approach.

WHAT'S BREWING

CONTINUED FROM PAGE 9

Peter N. Witt of Raleigh, director of the Division on Research, Department of Mental Health, "Biologic and Addictive Aspects."

Others will be: Dr. Samuel Mallov of Syracuse, N. Y., professor of pharmacology, State University of New York, Upstate Medical Center, "Pharmacology of Alcohol;" and Dr. Harrison M. Trice of Ithaca, N. Y., professor, New York State School of Industrial and Labor Relations, Cornell University, "Drinking Problems & the Work World."

Friday morning's lecturers and their subjects will be: Dr. William P. Wilson of Durham, N. C., professor of psychiatry, Duke University Medical Center, "Alcoholism and Brain Function;" and Judge John M. Murtagh of New York, N. Y., justice of the Supreme Court of the State of New York, "Law and Alcoholism."

Lecturers that afternoon will include: Dr. Thomas F. A. Plaut of Chevy Chase, Md., assistant chief of the National Center for Prevention and Control of Alcoholism, National Institute of Mental Health, "A National Overview of Alcoholism Problems: Their Control & Prevention;" and Dr. Ebbe Curtis Hoff of Richmond, Va., medical director, Bureau of Alcohol Studies and Rehabilitation, Medical College of Virginia Hospital, "Building a Model for the Comprehensive Treatment of Alcoholics and Their Families."

The lectures will be concluded with comments by Dr. Eugene A. Hargrove, Commissioner of Mental Health, who will also speak briefly on "Alcoholism Control in North Carolina."

The co-sponsors are: the N. C. Mental Health Association, Medical Society of the State of North Carolina, Roche Laboratories, Smith, Kline & French Laboratories and the N. C. Foundation for Mental Health Research, Inc.

EUPHORIA

CONTINUED FROM PAGE 3

never, never land, even when his drinking has progressed to the point where it is impossible. And it is a fact that as his drinking progresses he will know euphoria less and less.

This man is extremely hard to get at. He has not yet reached the desperation point which will allow him to go to a physician, A.A. or a counselor. At this stage he resents any hint that he just might be drinking a little too much, and he still has euphoria.

The search for euphoria has a devastating side effect on the victim—the evasion of maturity. As his preoccupation with drinking grows, so does his evasion of responsibility. Maturity, in my book, means taking an honest look at duties as they become clear and doing the best you can under all circumstances. A job, marriage, children, church and civic activities are vital functions in the role of a mature man.

The nonalcoholic usually makes the grade to adulthood from age twenty-five to thirty. His experiences in living have made lasting impressions and he has gained in wisdom.

This is not true for the budding alcoholic. He is far too busy perfecting the alibi system. He now comes up with an excuse for everything—a day out of work, nonattendance at church, late from work—an alibi or excuse for every duty he should have performed and didn't. It does not matter that, gradually, he will not be believed by anyone. The important thing to him is that he can justify himself to himself. In cold truth, the emotional imbalance is now in full flower and he will lie about even the simplest things, even in instances where a lie is unnecessary.

In the search for euphoria maturity is evaded.

In dealing with alcoholics, I try always to keep these two things in mind. I know the terrific hold euphoria has on him. And I am aware that he has not matured as a normal person should. I do not ask him for promises. I ask him to promise himself. This way, if he drinks again, he will not be ashamed to see me. To keep the door open is important. With the very few facts we have to work with, I think it is very necessary for me to be alert to any new avenues that may open on the emotional illness called alcoholism.

DIRECTORY OF OUTPATIENT FACILITIES

for

ALCOHOLICS AND/OR THEIR FAMILIES

Competent Help Is Available At The Local Level

Key to Facility and its Service

***Local Alcoholism Programs**
for
(Alcoholics and Their Families)
—Education
—Information
—Referral

†Mental Health Facilities
for
(Alcoholics and Their Families)
—Outpatient Treatment Services

‡Aftercare or Outpatient Clinics
for
(Alcoholics who have been patients of the N. C. Mental Hospital System)
—Outpatient Treatment Services

ASHEVILLE—

**Alcohol Information Center;* Parkway Offices; Phone: 704-252-8748.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Almance County Council on Alcoholism;* R. J. Cook, Executive Director; Room 802, N. C. National Bank Building; Phone 919-228-7053.

†*Alamance County Mental Health Clinic,* 221 Graham-Hopedale Rd.; Phone: 227-6271.

BUTNER—

‡*Aftercare Clinic; John Umstead Hospital;* Hours: Mon.-Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Calvin Burch, Box 277, Carrboro; Phone: 919-942-1089 or (if no answer) 919-942-1930.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: 704-375-5521.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 316 E. Morehead St.; Phone: 704-334-2834.

CONCORD—

†*Cabarrus County Mental Health Clinic,* 102 Church St.; Phone: 786-1181.

DURHAM—

†*Department of Psychiatry, Duke University Medical Center;* Phone: 648-8111, Ext. 3416.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; 919-682-5227.

ELIZABETH CITY—

*†*Alcoholism Center* (Camden, Chowan, Dare, Pasquotank and Perquimans Counties); Mrs. Rose Pugh, Director; Medical Bldg., P. O. Box 645; Phone: 919-335-1663.

FAYETTEVILLE—

†*Cumberland County Mental Health Center;* Cape Fear Valley Hospital; Phone: 484-8123.

GASTONIA—

†*Gaston County Mental Health Clinic,* 206 N. Highland St.; Phone: 864-8381.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m.-12.00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* Durwood Howard, Director; P. O. Box 1598; Phone: 919-735-7033.

†*Wayne County Mental Health Clinic,* 715 Ash St.; Phone: 735-4331.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 919-275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: 273-8281.

†*Family Service Agency;* 1301 N. Elm St.

GREENVILLE—

†*Coastal Plain Mental Health Center,* 1827 West Sixth St.; Phone: 752-7151.

**Pitt County Alcohol Information and Service Center;* Helen J. Barrett, Executive Secretary; P. O. Box 2371; 915 Dickinson Ave.; Phone: 919-758-4321.

HENDERSON—

†*Vance County Mental Health Clinic,* County Home Rd.; Phone 492-1176 or 438-4813.

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 158 By-pass W; P. O. Box 1174; Phone: 919-438-3274 or 919-483-4702.

HENDERSONVILLE—

Alcohol Information Center; S. Robertson Cathey, Director; 2nd Floor, City Hall; Phone: 919-692-8118.

†*Henderson County Health Department;* Phone: 692-4223.

HIGH POINT—

†*Family Service of High Point,* 113 Gatewood Ave.; Phone: 883-1709 or 833-2119.

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 919-883-2794.

LAURINBURG—

†*Scotland County Mental Health Clinic,* 1304 Biggs St.; Phone: 276-7360.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

**Burke County Council on Alcoholism;* Grady Buff, Educational Director; 211 N. Sterling St.; Phone: 704-433-1221.

NEW BERN—

*†*Alcoholism Division, Neuse Mental Health and Alcoholism Center;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 919-637-5719.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: 704-464-3400.

PINEHURST—

Sandhills Mental Health Center; Box 1098; Phone: 295-6851.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone: 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; 919-633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: 633-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St.; P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholism Program;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: 919-692-6631.

WADESBORO—

†*Anson County Health Department;* Phone: 694-2516.

**Education Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 704-694-2711.

WILMINGTON—

†*Southeastern Mental Health Center,* 920 S. 17th St.; Phone: 763-7342.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; P. O. Box 1435; Phone: 919-736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

**Wilson County Council on Alcoholism;* W. H. Jennings, Director; Room 208, 116 S. Goldsboro St.; Phone: 919-237-0585.

WINDSOR—

**Bertie County Alcohol Information and Service Center;* Rev. Donald Dawson, Director.

WINSTON-SALEM—

*†*Alcoholism Program of Forsyth County, Department of Mental Health;* Robert Charlton, Educational Director; 802 O'-Hanlon Bldg., 105 W. 4th St.; Phone: 919-725-5359.

†*Department of Psychiatry, Bowman Gray School of Medicine;* Phone: 725-7261.

†*Forsyth County Mental Health Unit,* Seventh and Woodland; Phone: 722-0364.

EDUCATION AND INFORMATION SERVICES

INVENTORY—quarterly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from the Film Library, N. C. State Board of Health, Raleigh, N. C. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—Family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Library Books—Books on alcoholism are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the books listed in the March-April, 1964 issue of **Inventory,** go to your community library and make the request.

Staff Speakers—members of the Raleigh and A.R.C. staffs are available for speeches before civic and professional groups.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the Education Division, N. C. Department of Mental Health, Raleigh.

Consultant Service—for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

Education Division, N. C. Department of Mental Health
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